National Rural Health Association

A View from the Hill: The State of Rural Health Policy

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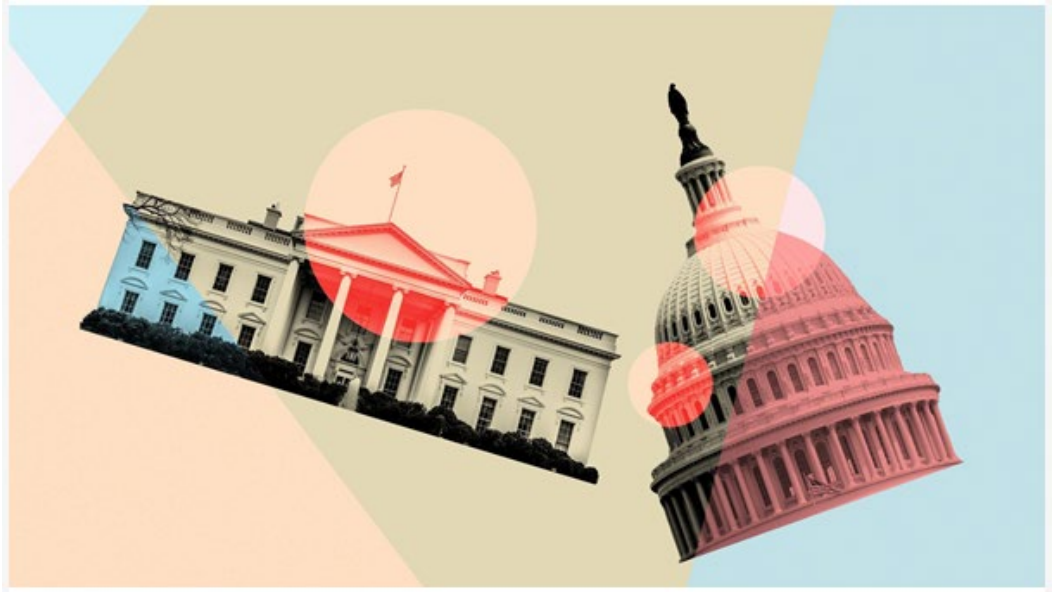

June 26, 2025

National Rural Health Association

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Our mission is to provide leadership on rural health issues.

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What We Fight for on Behalf of Rural

- Investing in a Strong Rural Health Safety Net
- Reducing Rural Healthcare Workforce Shortages
- Building Rural Health Opportunity

Today's Agenda

- **What's Happening in Congress?**
  - Reconciliation
  - FY26 Appropriations
    - Understanding the Presidents Budget
  - Key Health Legislation
- **Administration Updates**
  - HHS Reorganization
  - Regulation Updates
- **Advocating on Rural Health**

Budget Reconciliation

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What is budget reconciliation?

- Reconciliation is a special legislative process that can more easily advance fiscal legislation
- Budget resolution is needed to start the reconciliation process
  - A budget resolution is a document that outlines desired spending, revenue, debt, and deficit levels for the federal government over a specified period
  - Specifies targeted levels for federal spending
  - **Directs committees to cut or increase deficit by certain amounts**
    - **Key committees for healthcare: House Energy and Commerce, House Ways and Means, Senate Finance, Senate HELP**
- **For the most part, health policies are being considered as offsets in this process**

Budget reconciliation: Timeline

- Budget resolution passed both House and Senate last month, kicking off reconciliation process
- In the House: “Job is done” (For Now)
  - Initial Committee “mark ups” occurred on May 13th
  - House passed “One Big Beautiful Bill” Act on May 22nd
  - Achieved Speaker Johnsons goal to complete package before Memorial Day
- In the Senate: The work Begins
  - Initial closed-door sessions begin in early June.
  - Senators are due to meet throughout the week with expected amendments offered throughout Wednesday to Friday
  - Majority Leader Thune is aiming to pass their package before July 4th

Budget Reconciliation: The House

- The House passed reconciliation package One Big Beautiful Bill Act by a 215-214 vote.
- Congressional Budget Office estimates **nearly 11 million more people would be uninsured in 2034** as a result of proposals. With **7.7 million coming from Medicaid**.
- CBO scored the bill to have a **2.4 Trillion-dollar deficit increase** over 10 years.

Budget Reconciliation: The House

- House Republicans Pass Bill under the wire:
  - The Bill passed by a one vote margin with 2 fiscal hawks baulking the Speaker.
  - The House Republican Cacus has some infighting despite the House package passing with at least 2 members publicly admitting they didn't read the **1,036-page bill** and "would not vote for it if it returned in its current form."

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What's Next?

Senate Finance released their text (Medicaid, Medicare, ACA) Monday night

President and Speaker Johnson want **bill passed by July 4**

Majority Leader Thune said "the goal and the aspiration" is July 4 passage

Senate needs 51 votes to pass

Reconciliation Proposals:

How H.R. 1 and SFC Versions Differ

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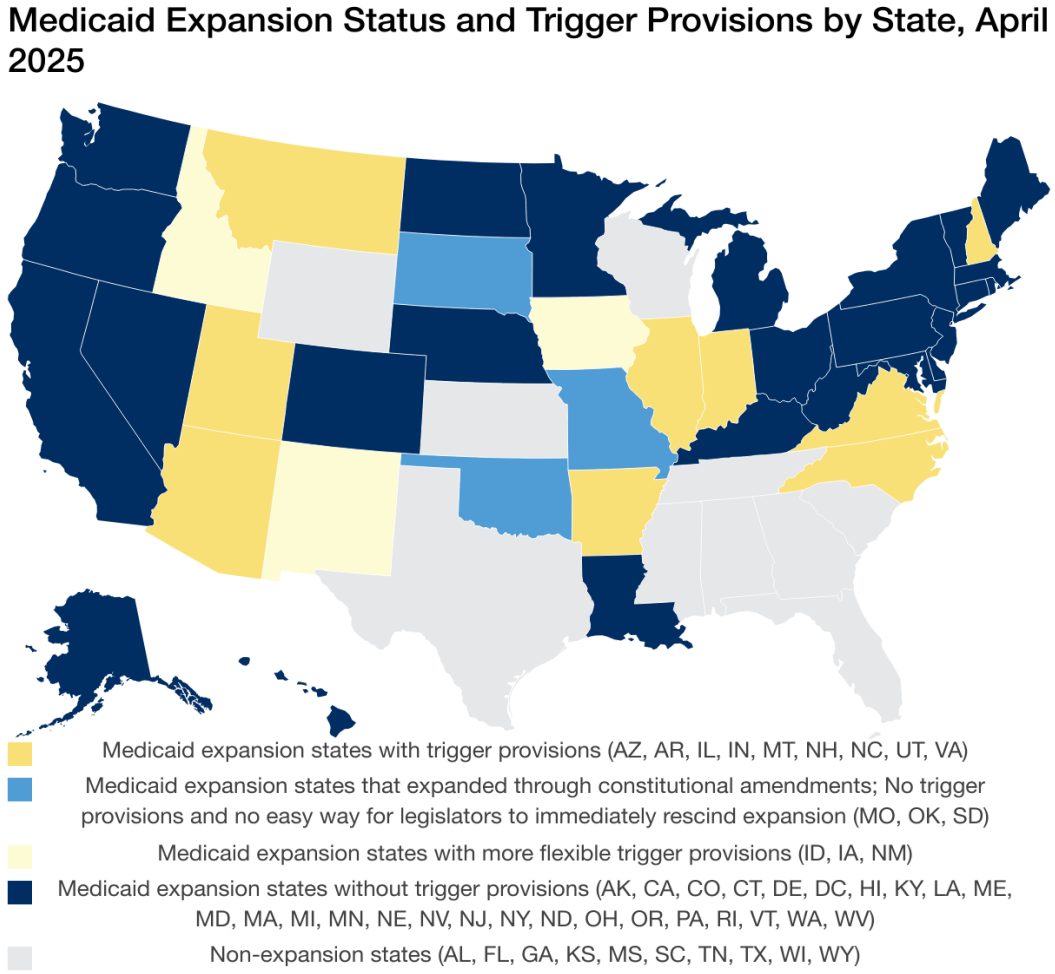
Medicaid and Reconciliation

- Direct changes to Medicaid Funding: Impact on SD
  - Such a cap would result in an effective reduction in the 90% FMAP with such reductions getting larger each year.
  - In the case of South Dakota:
  - In March 2025, the South Dakota legislature passed **a resolution to submit to voters a constitutional amendment for a trigger law that would allow the state to end the expansion if the enhanced federal match assistance percentage (FMAP) is reduced below 90%.** The measure will appear on the November 2026 ballot and require a simple majority of the vote to be approved.



Medicaid and Reconciliation

- Direct changes to Medicaid Funding:
  - Freezing states' provider taxes at current rates and prohibiting states from implementing new provider taxes.
  - Limiting future state directed payments to Medicare payment rate.
    - Non-expansion states incentive by allowing state directed payments to boost provider rates to 10% more than Medicare
  - Sunsetting eligibility for increased FMAP (+5%) for new expansion states.
  - 10% reduction in FMAP (80%) for expansion states who provide coverage for undocumented immigrants
  - Requires budget neutrality for section 1115 demonstration projects

H.R. 1: Provider Taxes

- As of 2018, provider taxes accounted for about **17% of states' share of the cost of Medicaid.**
- Freezes at current rates states' provider taxes in effect as of the date of enactment of this legislation and prohibit states from establishing new provider taxes.
  - This proposal is prospective – only impacts future taxes
- Limiting future increases or use of provider taxes will force states to reduce coverage, eliminate optional benefits, or reduce provider payments.
  - Could lead to less access to care and loss of coverage for rural patients.

SFC: Provider Taxes

- Non-expansion states would be prohibited from increasing rate of current provider taxes
- **Expansion states: Effectively reduces provider taxes to 3.5%**
  - Hold harmless threshold (6% currently) would be reduced by 0.5% annually until the maximum hold harmless threshold reaches 3.5 percent in 2031.
- Limits definition of “generally redistributive”
  - Provider taxes must be “broad-based” and “uniform” but states can apply for waiver of these reqs so long as tax is “generally redistributive”
  - This would effectively implement a pending CMS proposed rule
- Unlike H.R. 1, this is NOT PROSPECTIVE for expansion states

Medicaid and Reconciliation

- **Coverage related proposals: Work requirements**
  - 80 hours per month of work, community service, participation in a work program, OR enrolled in educational program at least half-time. *Moved to 2027 effective date.*
  - Exceptions for children, seniors, pregnant women, individuals with disabilities, those already meeting work requirements for TANF/SNAP, members of Tribes.
  - Short-term exceptions for natural disasters, time spent in inpatient care
  - Compliance determined 1 month preceding Medicaid enrollment and during redetermination. States can choose to do so more frequently.
  - Enrollees subject to work requirements that are not compliant would not be allowed to get Marketplace coverage

SFC: Work Requirements

- Largely the same as H.R. 1:
  - 80 hours per month of work, community service, participation in a work program, OR enrolled in educational program at least half-time
- No exemption for parents of children 14+

H.R. 1: State-Directed Payments

- Current regulations **allow states to direct payments from Medicaid managed care organizations** (MCOs) to provider to make up for chronically low Medicaid reimbursement rates
- The proposed bill limit future state-directed payments to providers by:
  - For expansion states, limiting SDPs to Medicare rate
  - For non-expansion states, limiting SDPs to Medicare rate + 10%
- Effective upon enactment
- Providers participating in Medicaid may begin to drop out due to lower reimbursement from Medicaid MCOs and limit care options for rural Medicaid enrollees
  - Could threaten the financial sustainability of rural providers and enrollee access

SFC: State-Directed Payments

- Non-expansion states: Limited to 110% of Medicare rate
- **Expansion states: Limited to 100% of Medicare rate**
- Existing state directed payments would be reduced by 10% annually until the allowable Medicare-related payment limit is achieved
- NOT prospective

Medicaid and Reconciliation

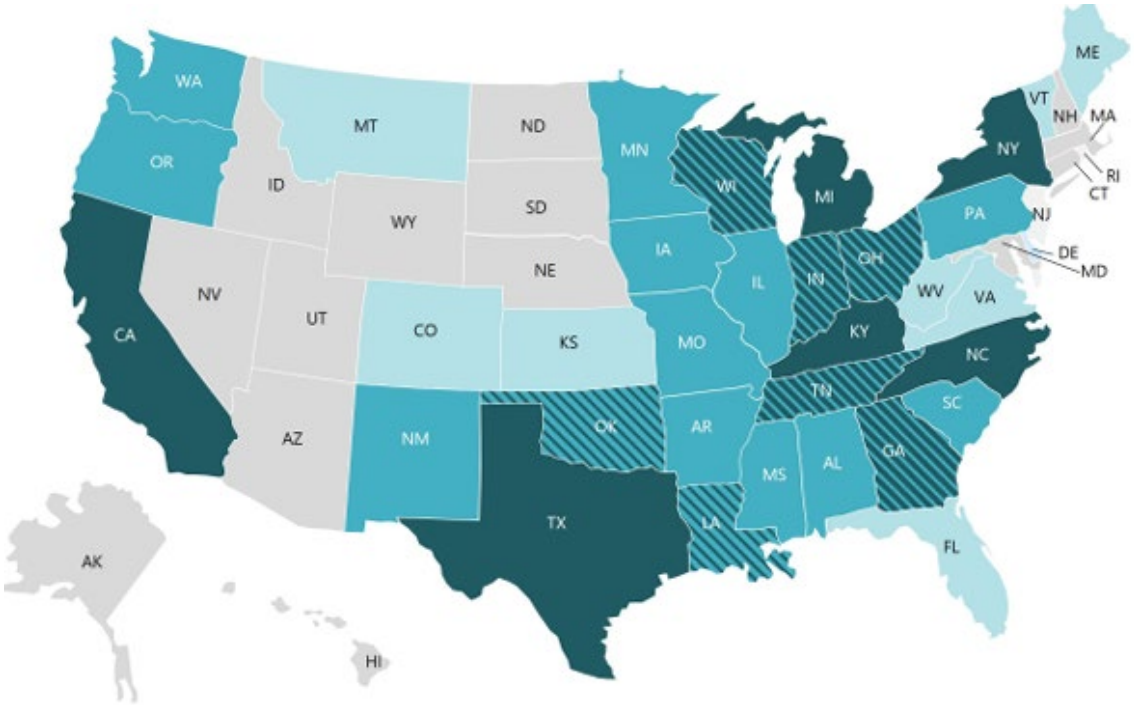
- Coverage related proposals
  - Limiting retroactive coverage to 1 month prior to individual's application date (currently 3 months)
  - **Increasing frequency of eligibility redeterminations for expansion adults to every 6 months (currently every 12 months)**
  - Revising home equity value limit for determining eligibility for LTC services – establishing a ceiling of $1 million
  - Removes180-day reasonable opportunity to verity citizenship/immigration status
  - Impose cost-sharing on expansion adults over 100% FPL (<5% income)
  - Delaying implementation of finalized rules that streamline Medicaid enrollment and eligibility until 2035

SFC: Coverage-Related Proposals

- Again, largely same as H.R. 1
- Limiting retroactive coverage preceding Medicaid enrollment:
  - 1 month for expansion population
  - 2 months for traditional Medicaid population
- Increasing frequency of eligibility redeterminations for expansion adults to every 6 months

Medicaid and Rural Hospitals

Importance of Medicaid in rural hospital communities

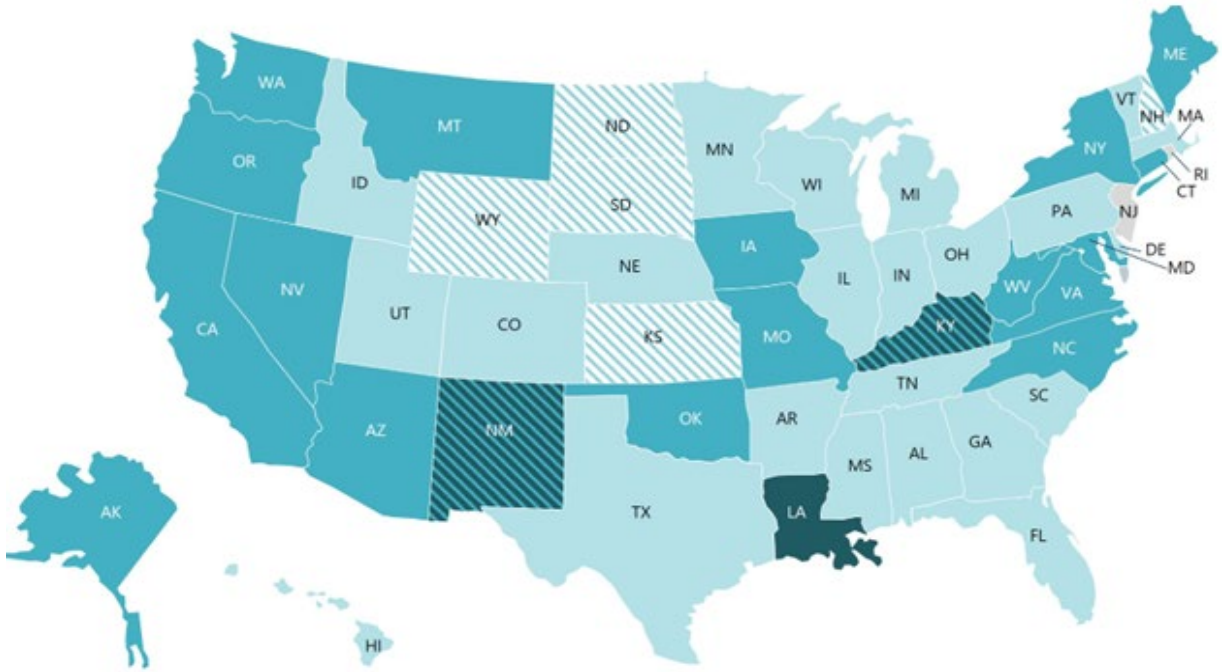


Estimated total Medicaid enrollees within rural hospital communities.

<100,000	100,001-200,000	200,001-300,000	300,001-400,000	400,001-500,000

Source: The Chartis Center for Rural Health, May 2025

At the median, Medicaid is 9.34% of total net revenue



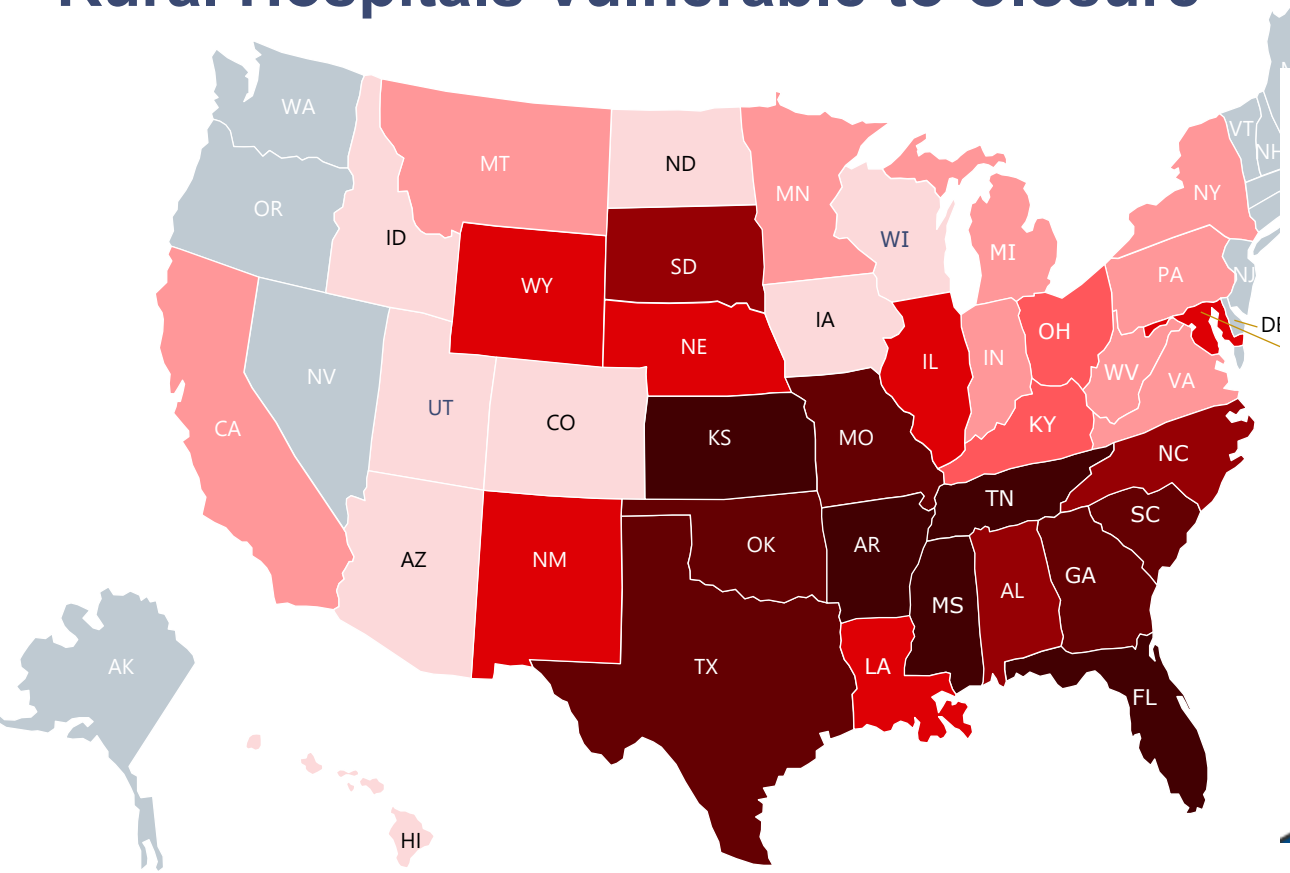
State median Medicaid as percentage of total net revenue

0%	1% – 5%	6% - 10%	11% - 15%	16% - 20%	>20%

Source: The Chartis Center for Rural Health, May 2025

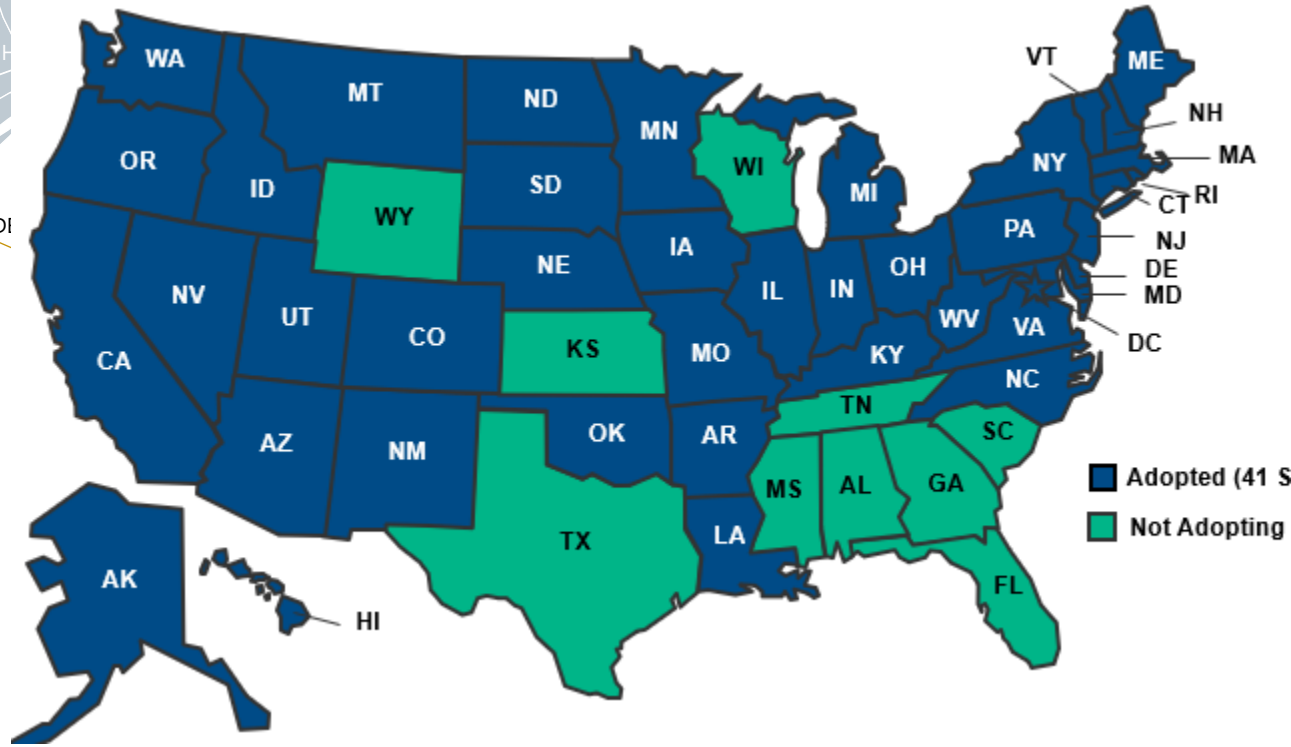
Implications for Rural Health Care Infrastructure

Rural Hospitals Vulnerable to Closure



Source: The Chartis Center for Rural Health, December 2024

Status of State Medicaid Expansion



SOURCE: "Status of State Medicaid Expansion Decisions: Interactive Map," https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

ACA Marketplace Proposals

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H.R. 1: ACA Marketplace

- Effectively ends auto-renewals of coverage
- Ends open enrollment one month early (Dec. 15)
- Ends year-round special enrollment period for individuals with incomes up to 150% of FPL
- Prohibits any special enrollment periods based on income
- Eliminates the tax credit for individuals that enrolled in a Marketplace plan through a special enrollment period based on annual household income.
- Institutes additional eligiblity and income verification
- Limits “lawfully present” to green card holders

SFC: ACA Marketplaces

- Individuals that enrolled in Marketplace coverage through a special enrollment period based on income are not eligible for premium tax credits (PTCs)
- Limiting PTCs to lawful permanent residents, certain Cuban immigrants, and COFA migrants
- Require verification of household income, immigration status, place of residence, family size, etc. in order to qualify for PTC
- Disallow partial repayments of excess advanced PTCs, requiring taxpayers to repay the full amount of any excess

Medicare Proposals

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H.R. 1: Medicare and Reconciliation

- Extends REH eligiblity to facilities closed between 2014-2021:
  - Requires completion of health assessment
  - Max number of 50 facilities
  - If closer than 35 miles to another hospital:
    - Must demonstrate that more than 50% of services are ED or observation for Medicare beneficaries
  - Payment methodology:
    - <35 miles from another hospital: No +5% for OPPS rate
    - <10 miles from another hospital: No +5% or monthly facility payment

H.R. 1: Medicare and Reconciliation

- “Doc fix” that would improve Medicare Physician Fee Schedule payment
  - Ties MPFS payments to 75% of the Medicare Economic Index in 2026, 10% in 2027 and beyond
  - Meant to soften impact of inflation, bring stability to MPFS updates
- Limiting Medicare eligibility to lawful permanent residents, certain Cuban immigrants, and individuals in the U.S. under COFA

SFC: Medicare

- **Did NOT include REH change or "doc fix"**
- Only Medicare provision is around eligibility:
  - Limiting Medicare eligibility to lawful permanent residents, certain Cuban immigrants, and individuals in the U.S. under COFA
- ***Good news***: Prohibiting implementation of Minimum Staffing for Long-Term Care Facilities rule
  - H.R. 1 delays implementation until 2035

Proposals: What's in and What's Out?

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H.R. 1 & Senate: Grad Loans

- Grad PLUS is a federal loan program that helps pay for graduate school costs not covered by other financial aid.
  - Many med students and other health professions rely on Grad PLUS loans to help with tuition and living expenses
- Starting **July 1, 2026**, Grad PLUS loans will no longer be available to new borrowers.
- Lifetime caps will be established for direct unsubsidized loans:
  - Graduate students: $100,000 total federal debt, $20,5000 per year
  - Professional students (MD, JD, DVM, etc.): $150,000 total, $50,000 per year
  - Aggregate cap across all federal loan programs: $200,000 per borrower
- Defers accrual of interest during first 4 years of residency

H.R. 1 & Senate: Public Service Loan Forgiveness (PSLF)

- PSLF: Participants must make monthly qualifying payments for 10 years
  - Must be at qualifying employer – nonprofit or public sector
  - After 10 years, remaining loans forgiven
- **Medical and dental internships and residencies will no longer qualify for PSLF credit**
  - Applies to borrowers without graduate school loans by **June 30, 2025**
  - To maintain PSLF eligibility for residencies, students must borrow a Grad PLUS or unsubsidized grad loan before **July 1, 2025**

More! Reconciliation

- **30% cut to federal funding for the Supplemental Nutrition Assistance Program (SNAP)**
- **Requires HHS to contract with artificial intelligence vendors to identify improper payments**
- Moratorium on implementation of long-term care facility staffing standards rule until 2035
- Delays DSH reductions to take effect 2029-2031
- Creates new single conversion factor based on percentage of MEI for physician fee schedule effective 2026

Reconciliation: What's Not Included

Medicare Reforms

- Medicare Site Neutrality
- Elimination of Medicare Coverage for Bad Debt
- Uncompensated Care Payment Reforms

Medicaid Reforms

- Per-Capita Caps

Extension of ACA Marketplace Subsidies

Elimination of Non-Profit Status for Hospitals

Rural Extenders: telehealth flexibilities, rural ambulance add-ons, and MDH designations

Proposals to Reform CMMI

Reconciliation Resources

- Advocacy Campaign: Urge Congress Against Cuts to Medicaid
  - ***Include your own story/perspective!***
- Medicaid Cuts and Rural Impacts fact sheet
- Rural Medicaid talking points
- NRHA statement on impact of Medicaid cuts on rural
- NRHA Member Perspective: *Critical Condition: How Medicaid Cuts Would Reshape Rural Health Care Landscapes*

Reconciliation Resources

- Rural Medicaid Toolkit – Includes links to all NRHA resources
  - Template letter to Senators
  - Template op-ed
  - Link to advocacy campaign + how to use our advocacy campaigns

FY26 Appropriations and The Presidents Budget

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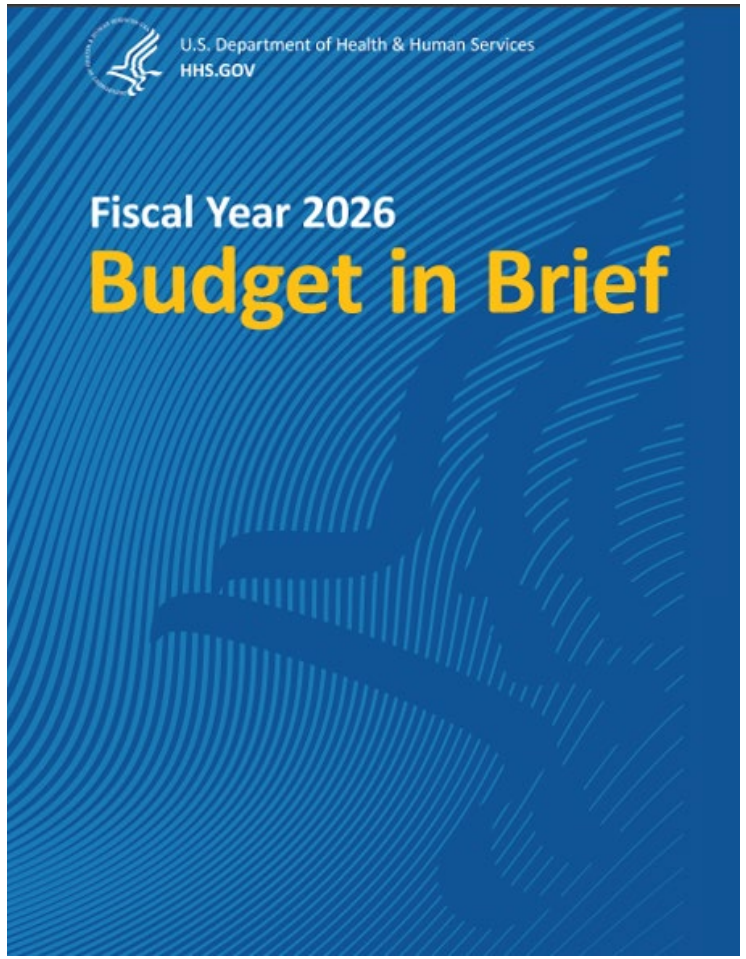
FY26 Appropriations: Timeline

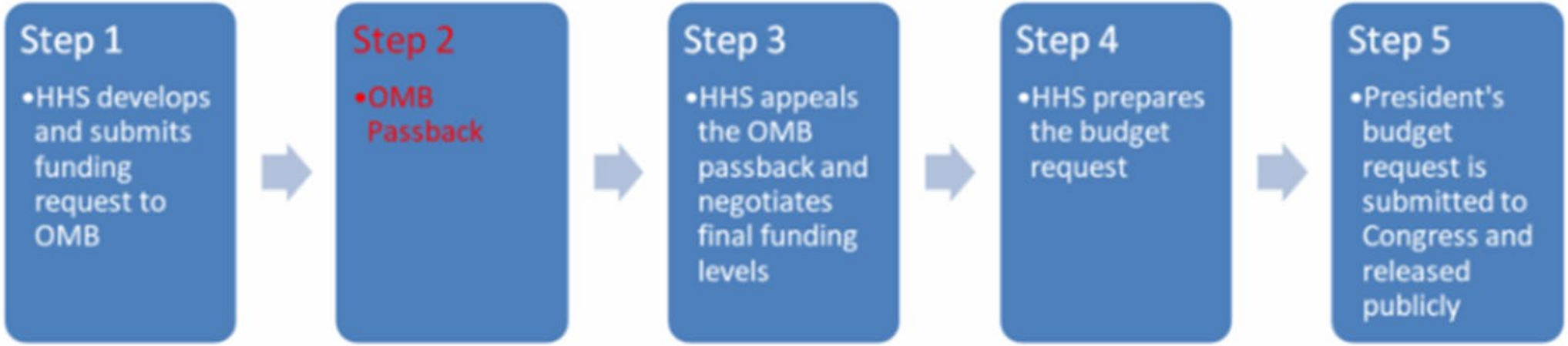
- Late April: A leaked draft of the President's Budget circulated, which included proposed FY 2026 funding levels and information on the HHS reorganization
- May 23rd: House and Senate FY26 Labor-HHS Appropriation Request Deadline
- May 31st at 4:55pm ET: FY26 President Budget Details Released
- July 21st: House Labor-HHS Subcommittee Markup
- July 24th: House Full Appropriation Markup



FY 2026 Appropriations

Where we were

Where we are



FY 2026 President's Budget Request

Based on the President's "skinny budget" released

- HHS would see 26.2% cut from FY 2025 enacted level
  - $7.2 billion for HRSA, a 19.4% decrease
  - $3.0 billion in discretionary funding for CMS, an 18.3% decrease
  - $5.6 billion in discretionary funding for CDC, a 38.9% decrease
  - $240 million in discretionary funding for AHRQ, a 35% decrease
  - $29.3 billion for NIH, a 38% decrease
  - $6.2 billion for SAMHSA, a 14.3% decrease

- What's on the "Block"

FY 2026 President's Budget Request

- **Medicare Rural Hospital Flexibility (Flex) Program**
  - **President's Budget: $0**
  - **NRHA Request:** $75 million. The Flex Program supports Critical Access Hospitals (CAHs) in improving quality, financial stability, and emergency services. Nearly half of rural hospitals currently operate with negative margins, and over 180 have closed or cut inpatient care since 2005. Additional Flex funding is urgently needed to sustain operations, prevent further closures, and support EMS coordination in underserved areas.

FY 2026 President's Budget Request

- **State Offices of Rural Health (SORHs)**
  - **President's Budget: $0**
  - **NRHA Request:** $15 million. SORHs operate in every state and serve as the backbone of rural health planning and coordination. These offices assist rural providers in workforce development, grant access, data analysis, and quality improvement initiatives. Increased investment will enable SORHs to expand technical assistance and strengthen local health infrastructure.

FY 2026 President's Budget Request

- **Rural Hospital Technical Assistance (USDA)**
  - **President's Budget:** $0
  - **NRHA Request:** $5 million. This pilot program provides targeted, on-site technical support to help rural hospitals improve performance and avoid closure. Given the number of hospitals on the brink of shutting down, eliminating this support would severely reduce access to critical care in many regions.

FY 2026 President's Budget Request

Rural Residency Planning and Development Program (RRPD)

- **President's Budget:** $12.7 million
- **NRHA Request:** $14 million. Since 2019, the program has helped launch 48 rural residencies and created over 580 new training positions.

Rural Communities Opioid Response Program (RCORP)

- **President's Budget:** $145 million
- **NRHA Request:** $155 million. RCORP addresses the opioid epidemic and broader substance use challenges in rural areas by funding prevention, treatment, and recovery services.

FY 2026 President's Budget Request

- Unspecified in the Outlined Budget:
  - Rural Health Care Services Outreach, Network, and Quality Improvement Grants
  - Rural Health Research and Policy Development Program
  - CDC Office of Rural Health

- Notations in the HHS Circulated document:
  - Rural is largely mentioned in the "Fighting the chronic disease pandemic" and "food systems" sections.
  - "The budget eliminates the following programs to align investments with the Administration's priorities, streamline the bureaucracy, reset the proper balance between federal and state responsibilities, and save taxpayer funds."

FY26 Presidents Budget

- Significant cuts of 30% or $40b across HHS alone
- AHA's Primary Care Office would be funded at $6.9b
- Eliminates core rural health programs:
  - Medicare Rural Hospital Flexiblity Grants
  - State Office of Rural Health Grants
  - Rural Residency Development Program Grants
  - At-Risk Rural Hospital Program Grants
  - Certified Community Behavioral Health Clinics
  - Significant cuts across workforce programs including Area Health Education Centers, nursing programs, oral health, behavioral health
- Other programs level funded at FY24 levels

FY 2026 President's Budget Request

- Programs that were formerly in HRSA that are were deemed redundant or need to be streamlined and will be eliminated or moved to AHA:

Healthy Start	Newborn Screening for Heritable Disorders	Early Hearing Detection and Intervention
Emergency Medical Services for Children	Ryan White Part F	Rural Hospital Flexibility Grants
State Offices of Rural Health	Rural Hospital Stabilization	Family Planning Programs
15 Workforce Programs, including:	Nursing Workforce Programs	Medical Student Education

FY 2026 House Agriculture Approps

- House Appropriations Agriculture, FDA bill includes:
  - $2 million for Rural Hospital Technical Assistance
  - $90 million for ReConnect Broadband Program
  - $30 million for Distance Learning and Telemedicine Program
  - $1.9 billion for Community Facilities Loans

FY 2026 Appropriations Requests

	NRHA FY 26 Request	President's FY 26 Budget	HAC FY 2025 Bill	SAC FY 2025 Bill	FY 2025 Enacted
Rural Hospital Flexibility Grants	$75 million	$0	$75 million	$64 million	$64 million
Rural Hospital Stabilization Pilot Program	$15 million	$0	$15 million	$6 million	$4 million
Rural Residency Planning & Development	$14 million	$12.7 million	$14 million	$14 million	$13 million
State Offices of Rural Health	$15 million	$0	$13 million	$14.5 million	$12 million
CDC Office of Rural Health	$10 million	TBD	$5 million	$5 million	$5 million
Outreach Programs	$109 million	$101 million	$109 million	$106 million	$101 million
RCORP Program	$155 million	$145 million	$145 million	$155 million	$145 million

Appropriations Resources

- Advocacy campaign: Urge Congress to Invest in Rural Health
- NRHA FY 26 Appropriations requests one pager
- State delegation template letter with state and district data
- Medicare Rural Hospital Flexibility talking points and fact sheet
- State Offices of Rural Health talking points and fact sheets
- Rural Residency Planning and Development fact sheet
- NRHA Congressional FY 2026 appropriations letter

NRHA Appropriations hub

HHS Reorganization

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Cabinet Nominees

Robert F. Kennedy Jr.	HHS Secretary	Sworn in 2/13
James O'Neill	HHS Deputy Secretary	Pending full Senate Vote
Dr. Mehmet Oz	CMS Administrator	Sworn in 4/7
Tom Engels	HRSA Administrator	Sworn in 2/14
Marty Makary	FDA Commissioner	Confirmed 3/25
Susan Monarez (Acting Director)	CDC Director	Pending Senate Confirmation
Dr. Jay Bhattacharya	NIH Director	Confirmed 3/25
Dr. Casey Means	Surgeon General	Pending Senate Confirmation
Doug Collins	VA Secretary	Sworn in 2/5
Brooke Rollins	USDA Secretary	Sworn in 2/13
Russell Vought	OMB Director	Sworn in 2/6

HHS Reorganization

Centralization & Consolidation:

- Cut 20,000 jobs
- 28 divisions consolidated into 15
- 10 regional offices to 5
- Centralize HR, IT, contracts, IEA
- New Assistant Secretary for Enforcement to provide oversight and to combat waste, fraud, and abuse
- Administration for a Healthy America (AHA) will consolidate elements of the OASH, HRSA, SAMHSA, ATSDR, and CDC
- Disbands Administration for Community Living (ACL) to the Administration for Children and Families (ACF), ASPE, and CMS
- Combine ASPE and AHRQ into the Office of Strategy to conduct research, inform policy, and evaluates the effective

HHS Reorganization

- **Administration for a Healthy America**
  - HRSA, SAMHSA, Office of Assistant Secretary for Health, National Institute for Environmental Health Sciences, some CDC offices
- **Centers for Medicare and Medicaid Services**
  - 340B Office of Pharmacy Affairs moved from HRSA to CMS
- **Administration for Community Living**
  - Disbanded, offices moved to the Administration for Children and Families, ASPE, and CMS

HRSA
Health Resources & Services Administration

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Department for Health and Human Services: *Tentative*

Office of the Secretary	Administration for a Healthy America	Administration for Children & Families	Centers for Medicare & Medicaid Services
Centers for Disease Control & Prevention	National Institutes for Health	Food & Drug Administration	Indian Health Service

Administration for a Healthy America: *Tentative*

Primary Care (HRSA/ CDC)	Maternal & Child Health (HRSA/CDC)	Mental Health (SAMSHA)	Environmental Health (CDC/ NIOSH)
HIV/AIDS (HRSA/OASH)	Health Workforce (HRSA)	Surgeon General	Policy, Research, & Evaluation

AHA- Primary Care: *Tentative*

- Bureau of Primary Care (HRSA)
- Office of Rural Health (HRSA)
- Health Systems Bureau (HRSA)
- Telehealth (HRSA)
- Office of Minority Health (OASH)
- National Center for Injury Prevention & Control (CDC)

Make America Health Again (MAHA)

- Presidential commission led by Health Secretary Kennedy
- $500 million to establish a MAHA Commission focused on fighting chronic disease
  - Initial focus on childhood chronic diseases (e.g. roots of autism)
  - Approach to chronic disease through holistic approaches and overuse of medicine
  - To set priorities for AHA spending
- Initial report released May 22, 2025
  - Explains the potential drivers of childhood chronic disease as poor diet, environmental chemicals, lack of physical activity, chronic stress and overprescribing of medications to children
  - Doesn’t set out specific policy prescriptions; offers up carefully selected studies and proposes new research

FY25 Recission Package?

- GAO reviewing elimination of programs for violation of Impoundment Control Act
  - Rescissions request or propose new legislation to make changes to funding mandates already signed into law
- A $9.3b recission package was expected after Easter recess
  - Cancel Congressional approved FY25 funding levels
  - Will require a simple-majority in each Chamber to pass
- Details still TBD:
  - State Department, USAID, Institute of Peace
  - Corporation for public broadcasting

Key Health Legislation

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Medicare Extenders (118th)

Key rural health and safety net program extensions through October 1, 2025:

- **MDH and LVH Programs** extended ensuring financial stability for rural PPS hospitals.
- **Medicare Ambulance Bonus Payments** continued supporting rural EMS reimbursement.
- **Telehealth Flexibilities** extended allowing RHCs and FQHCs as distance site providers.
- **Funding Extensions** for the National Health Service Corps (NHSC), Community Health Centers (CHC), and Teaching Health Center Graduate Medical Education (THC GME).
- **Medicaid DSH Reduction Delay** preventing funding cuts for rural safety-net hospitals.
- **Hospital Care at Home Waiver** extended allowing in-home acute care services.

Senate CDC Reform Working Group

- Senate Republican working group to examine legislative reforms to CDC.
- Senators Bill Cassidy, M.D. (R-LA), Ron Johnson (R-WI), Mike Lee (R-UT), Roger Marshall, M.D. (R-KS), Lisa Murkowski (R-AK), Rand Paul (R-KY), and Tim Scott (R-SC)
- Cassidy RFI on CDC reform in 2023.
  - NRHA response.

Senate 340B Working Group

- “Gang of 6” in Senate is working group on 340B reform.
- Stabenow, Cardin retired from Senate after 118th; future of group was unclear at beginning of 119th Congress.
  - Thune (R-SD) now in leadership position and did not return.
- Senators Kaine (D-VA), Mullin (R-OK), and Hickenlooper (D-CO) are joining the Working Group.
  - Returning members: Moran (R-KS), Baldwin (D-WI), Capito (R-WV).
- Group is focused on reviewing and completing draft legislation from last Congress.
- Any movement unlikely until after reconciliation.

Senate 340B HELP Study

- HELP report Congress Must Act to Bring Needed Reforms to the 340B Drug Pricing Program
- Reforms to be considered:
  - Annual reporting requirements for select covered entities
  - Changes to the definition of eligible 340B patient
  - Clarifications on contract pharmacies' fees
  - Common use of the inventory replenishment model

NRHA 340B Advocacy Materials

Rulings and Rules…

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Court Challenges

- HHS funding freeze- *appealed, government response May 27th*
- DEI executive orders- *in place, pending court decision*
- Harvard case on NIH grant termination- *oral arguments in July*
- HHS employee termination for probationary workers- *appealed, government brief due May 22nd*
- Other cases on FOIA, DOGE access, HHS datasets and websites

NRHA Administration Priorities: First Year Proposals

- Empower Rural
  - Hold MA plans accountable
  - Establish a Rural Hospital Network Initiative
- Deregulation
  - Remove administrative burdens
  - Address outdated cost report policy
- Rural Health Care Reforms
  - Extend current site neutral exemptions to Medicare-dependent hospitals
  - Modernize Rural Health Clinic program
  - Clarify REH payments under Medicaid
- Rural Workforce Training
  - Allow REHs to serve as NHSC sites
  - All SCH and MDH to receive indirect medical education payments

Executive Orders

- Administration ordered HHS to freeze all external communications
- Issued Regulatory Freeze Pending Review
- Rescinds E.O. “Lowering Prescription Drug Costs for Americans”
- Rescinded several Biden executive orders related to guiding strategies and policies related to the COVID-19 pandemic
- Rescinded a January 2022 executive order that reopened federal health insurance exchanges for open enrollment for a special enrollment period
- Withdraw the US from the World Health Organization
- Rescinded Biden's “Executive Order on Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence
- Dismantle diversity, equity, and inclusion (DEI) initiatives across various sectors.
- Rescinded numbers E.O.s related to non-discrimination and equality in gender and sexual orientation
- Reforming the Federal workforce

More available at https://www.whitehouse.gov/presidential-actions/2025/01/initial-rescissions-of-harmful-executive-orders-and-actions/; https://chcoc.gov/transmittals

Executive Order

Most-Favored-Nation Pricing Targets (May 12, 2025)

- Reducing prescription drug prices by implementing a most-favored-nation (MFN) pricing policy
- Aimed at getting voluntary price concessions from manufacturers
- Facilitate direct-to-consumer purchasing programs for manufacturers that sell their products to American patients at the most-favored-nation price

Lowering Drug Prices (April 15, 2025)

- Conduct survey on acquisition cost for outpatient drugs
- Condition “future grants” on health centers making insulin and epinephrine available at or below 340B discounted price
- HHS Secretary must evaluate to ensure Medicare payment does not shift drug administration from physician offices to hospital outpatient departments

Executive Orders

Making America Healthy by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing

- Directs HHS, Treasury Department, and Labor Department to “rapidly implement and enforce” price transparency regulations.
- Within 90 days, agencies must:
  - Require disclosure of **actual prices, not estimates**.
  - Issue updated guidance or proposed regs ensuring price information is standardized and easily comparable across hospitals and plans.
  - Issue guidance or proposed regs updating enforcement policies designed to ensure compliance with transparent reporting of complete, accurate, and meaningful data.

Regulatory Relief Requests for Information

- Office of Management and Budget RFI: Deregulation
  - Soliciting “ideas for deregulation from across the country.”
  - Asking for commenters to identify rules to be rescinded and provide detailed reasons for rescission
  - NRHA Comment letter here.
- CMS RFI: Unleashing Prosperity Through Deregulation of the Medicare Program
  - Responses were due June 10
  - Existing regulatory requirements that can be waived, streamlined?
  - What administrative processes or quality/data reporting are most burdensome?
  - What changes can be made to simplify reporting and documentation requirements?

CY 2026 Medicare Advantage & Part D Final rule

- Prior authorization highlights
  - Cannot approve an inpatient admission during a concurrent review and later deny services based on a lack of medical necessity.
  - Beneficary and provider appeals process clarified.
- Implements several Inflation Reduction Implementation -related provisions affecting Medicare drug coverage.
- Part D payment and price transparency
  - Finalized the Medicare Prescription Payment Plan and auto-enrollment for renewal
  - Requirements for Part D plan sponsors
- Deferred proposals:
  - Did not finalize coverage of GLP-1 receptor agonists
  - Proposals regulating AI in prior authorization were deferred
  - Marketing reforms, including redefining marketing materials and tightening provider directory accuracy requirements

Expansion of Buprenorphine Treatment via Telemedicine Encounter

- Final rule from DEA and HHS effective Feb. 18, 2025.
- Applies to practitioner prescribing Schedule III-V controlled substances for opioid use disorder without in-person exam.
- Practitioners may prescribe 6-month supply of buprenorphine via telemedicine, including audio-only
- Update: In February, delayed until March 21, 2025. **Now delayed again until December 31, 2025.**
  - Patients can still get virtual prescriptions through the end of the year through an extension of COVID-19 flexibilities.

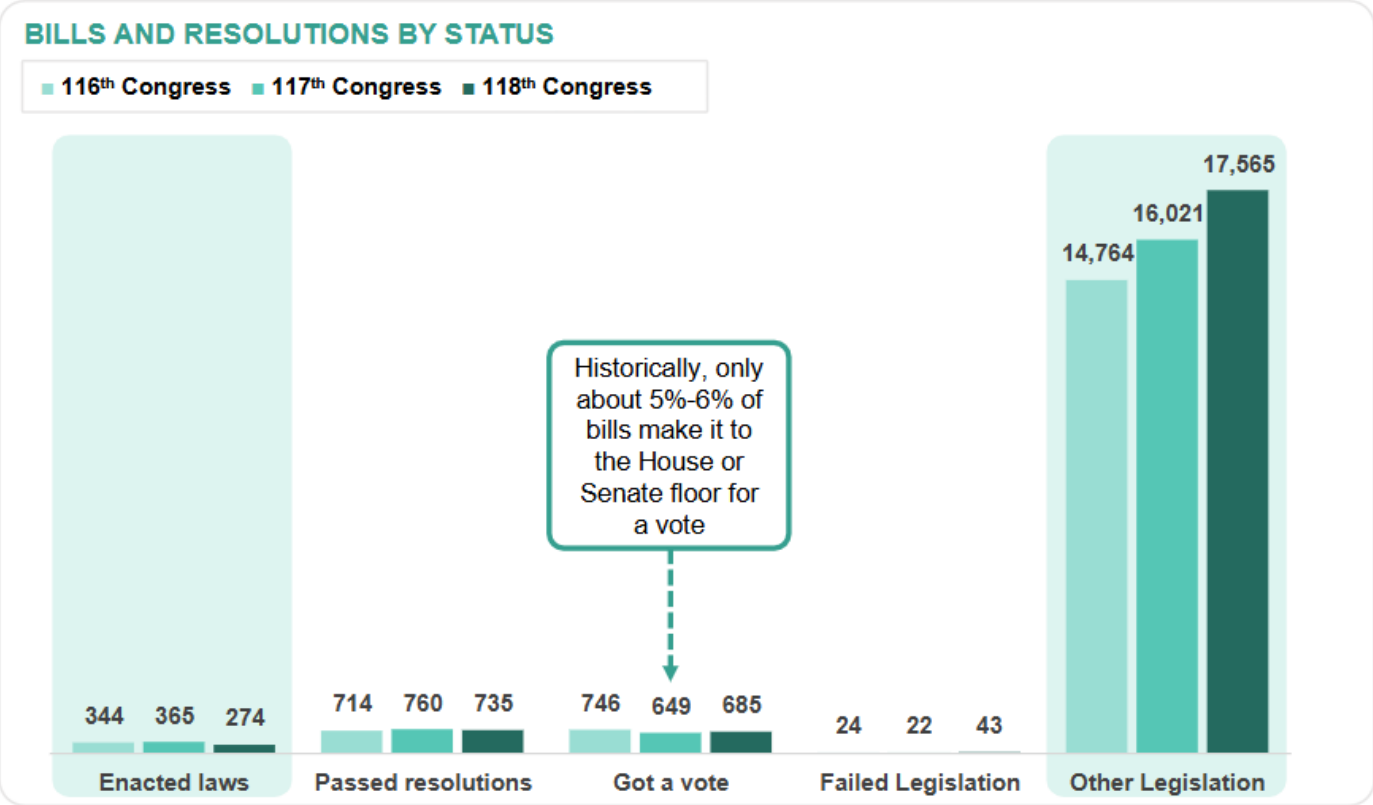
Advocate With Us!

NRHA
Your voice. Louder.

National Rural Health Association

Why Coalition?

Making Change is Hard – By the Numbers



- Over 17,000 bills were introduced in the 118th congress.
- Less than 700 got a vote.
- Less than 275 were made into law.
- So what do we do?

Source: NJ via GovTrack

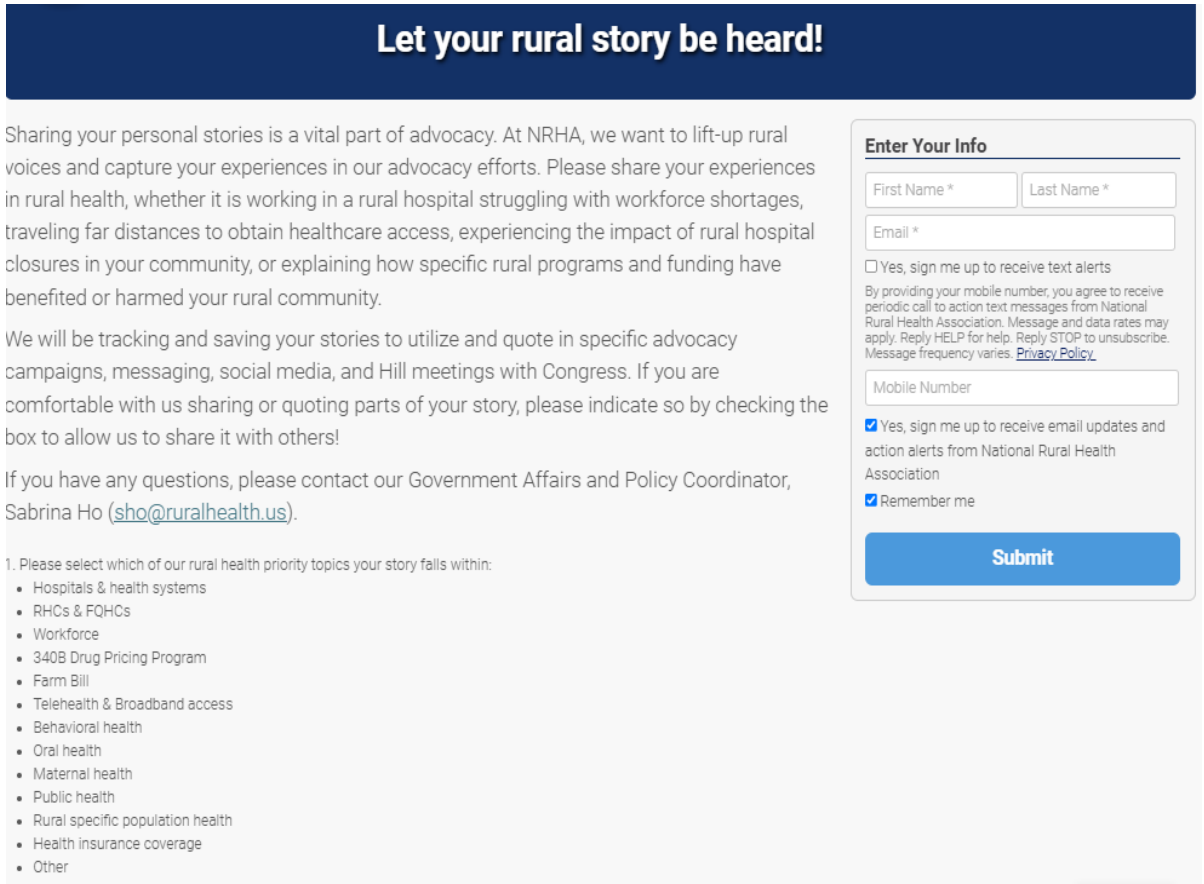
State Resources

- Policy Requests and Inquiries:
  - If you, your school, or your organization has questions about a specific legislation **NRHA will investigate and summarize the legislation** or help connect you with State Lawmakers.
  - NRHA members **can request a letter of support** for state specific legislation, please email Zil Joyce Dixon Romero at zjdromero@ruralhealth.us with inquiries.
  - **Opinion Editorials.** NRHA Staff is happy to coauthor op-eds with you.
- Advocacy Efforts:
  - NRHA is working with the State Rural Health Associations to address specific state-level issues.
  - Full Presentation on Advocacy vs. Education vs. Lobbying.

Advocacy Campaigns

"Rural Stories" Advocacy Resource

- The most impactful advocacy tool you have is your story.
- Share your experiences in rural health.
- NRHA will be tracking and saving your stories to utilize and quote in specific advocacy campaigns, messaging, social media, and Hill meetings with Congress to lift up your voices!



Let your rural story be heard!

Sharing your personal stories is a vital part of advocacy. At NRHA, we want to lift-up rural voices and capture your experiences in our advocacy efforts. Please share your experiences in rural health, whether it is working in a rural hospital struggling with workforce shortages, traveling far distances to obtain healthcare access, experiencing the impact of rural hospital closures in your community, or explaining how specific rural programs and funding have benefited or harmed your rural community.

We will be tracking and saving your stories to utilize and quote in specific advocacy campaigns, messaging, social media, and Hill meetings with Congress. If you are comfortable with us sharing or quoting parts of your story, please indicate so by checking the box to allow us to share it with others!

If you have any questions, please contact our Government Affairs and Policy Coordinator, Sabrina Ho (sho@ruralhealth.us).

1. Please select which of our rural health priority topics your story falls within:
   - Hospitals & health systems
   - RHCs & FQHCs
   - Workforce
   - 340B Drug Pricing Program
   - Farm Bill
   - Telehealth & Broadband access
   - Behavioral health
   - Oral health
   - Maternal health
   - Public health
   - Rural specific population health
   - Health insurance coverage
   - Other

Enter Your Info

First Name * | Last Name *

Email *

☐ Yes, sign me up to receive text alerts

By providing your mobile number, you agree to receive periodic call to action text messages from National Rural Health Association. Message and data rates may apply. Reply HELP for help. Reply STOP to unsubscribe. Message frequency varies. Privacy Policy

Mobile Number

☑ Yes, sign me up to receive email updates and action alerts from National Rural Health Association

☑ Remember me

Submit

NRHA's Legislative Tracker

Legislative Tracker

NRHA is tracking rural health legislation in Congress to advance quality of life across rural America.

NRHA's legislative tracker enables you to view the rural health bills in Congress the association is monitoring, including those we endorse and oppose. Bills are searchable and categorized by topic area. By clicking on a bill, you can find its summary, review cosponsors, and stay up to date on congressional actions.

Through activities such as NRHA's annual **Rural Health Policy Institute** and **ongoing grassroots campaigns**, NRHA members actively participate in advocacy efforts to advance needed rural health legislation.

For further information or to recommend bills for the legislative tracker, **contact NRHA's government affairs team**.

Find Legislation

Federal | Enter Keywords | Search

Hospitals & Health Systems

- H.R. 833: Save America's Rural Hospitals Act | 2023-2024 Regular Session (118th) ✓
- H.R. 1712: Rural Health Innovation Act of 2023 | 2023-2024 Regular Session (118th) ✓
- H.R. 2423: To affirm that the Farm Credit Administration is the sole and independent regulator of the Farm Credit System. | 2023-2024 Regular Session (118th) ✓
- HR 1565: Critical Access Hospital Relief Act of 2023 | 2023-2024 Regular Session (118th) ✓
- S. 803: Save Rural Hospitals Act of 2023 | 2023-2024 Regular Session (118th) ✓
- S. 1110: Rural Hospital Support Act of 2023 | 2023-2024 Regular Session (118th) ✓

2025 NRHA Advocacy Resources

- Sign up to receive NRHA's Rural Roundup & NRHA Today.
- NRHA advocacy website
- Register for NRHA's Monthly Grassroots Call.
- Contact your NRHA Government Affairs Team:
  - Email: Carrie Cochran-McClain, Alexa McKinley Abel, Zil Joyce Dixon Romero, Sabrina Ho, Marguerite Peterseim
- Engage with NRHA Advocacy online!

National Rural Health Association

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Comments? Questions?

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https://www.ruralhealth.us/advocacy

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